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Management Development in the Korean National Family Plannning Program***

I. INTRODUCTION

The Korean population in 1980 was over 38 million, more than double the population of thirty years ago. At 385 persons per square kilometer in 1980, Korea is among the world's most densely populated nations. The Korean national family planning program began in 1962, originating both from a concern for family well-being and from awareness that high population growth rate effectively cancels advanced in economic development.

Korea adopted the program conscientiously, providing a budget from economic development funds and deploying a large corps of fulltime fieldworkers. Annual targets were set through consultation with local administrators as well as with health officials. Mass media techniques were utilized for public education, and the program's aims were endorsed in statements by prominent national leaders. Besides the provision of services through education and recruitment, there were distinctive activities by the military, schools, and other institutions toward legitimation of birth planning and endorsement of the small family ideal.

The program has been in the "maintenance" stage since the early 1970s after having

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gone through the stages of initiation, programming, and expansion in the 1960s. At the current stage, there is a need to consolidate the experience gained so far, and to achieve increased efficiency and effectiveness needed for further fertility reduction.

In the past years, numerous research and evaluation projects have been conducted with the goal of assessing levels of fertility change and contraceptive usage. Little of the research and evaluation, however, has focused on improving the management of the program. Furthermore, utilization of research is still in a rudimentary stage, despite increased efforts in the last few years.

With the considerations above, this paper concentrates on the management development aspect of the national family planning program, which in Korea forms the basic means of government intervention to reduce fertility.

II. PROGRAM HISTORY AND DESCRIPTION

A. Policy and Goal

Throughout its history, the program has been guided by a clear policy with a definite goal for fertility reduction, and it has been backed by continuous political commitment. Since 1962, when the First Five-Year Economic Development Plan started, fertility reduction has been a high priority and family planning program an integral part of the national development plan. The demographic goal has been translated into family planning program objectives in the form of annual acceptor targets, eventually translated into budgetary allocations. The Economic Planning Board considers the family planning budget in the "investment" section.

In 1963, the Prime Minister issued the "Family Planning Enlightment Plan" to promote the program as a priority government project, specifying actions to be taken by ten different Ministries. On many occasions, the President has stressed the family planning program in his New Year policy statment. In 1973, the government issued an executive order directing all Ministries to cooperate in family planning promotion and in the enactment of the Maternal and Child Health Law legalizing induced abortion. In order to sustain strong and continuous interest among highranking policy makers and to implement comprehensive population policies through interministrial cooperation, the

Population Policy Deliberation Committee (PPDC) was established in 1976 under the chairmanship of the Deputy Prime Minister. However, population policy in Korea has been largely implemented through direct family planning activities.

B. Objectives and Achievements

The nation's goal in the first ten years of the National Family Planning Program was to reduce the rate of population growth from 2.9 percent in 1962 to 2.0 percent in 1971. This goal was reached successfully. Subsequent demographic targets were established to further reduce the population growth rate to 1.6 percent by 1981. The 1980 census figures and other studies indicated that the crude birth rate had in fact fallen from 43.0 to 23.4 per thousand population between 1960 and 1980, and the population growth rate from 2.8 percent to 1.6 percent during the same period. According to the Fifth Five-Year Economic Social Development Plan (1982-1986) established by the Government, the new demographic targets have been set for further reduction of population growth rate to around 1.5 percent in 1986 under the assumption that the population replacement level (TFR:2.1 or NRR:1) is to be attained by 1988.

The total fertility rate declined from 6.0 in 1960 to 2.6 in 1979, a 57 percent decline. As shown in Table 1, the age specific fertility rate on the whole also indicates drastic changes during the same period. However, the fertility rate for the age group 25-29 declined relatively less in comparison with other age groups. This pattern for the

Table 1. Age Specific and Total Fertility Rates by Selected Years: 1960—1979

Age Group	1960	1971	1974	1976	1979	Percent Decline (1960—1979)
15—19	35	6	11	10	8	77%
20—24	251	195	159	147	145	42
25—29	326	348	276	275	248	24
30—34	275	241	164	142	94	66
35—39	206	97	74	49	27	87
40—44	97	63	29	18	7	93
TFR	6.0	4.8	3.6	3.2	2.6	57

Source : KIFP, *1979 Korea Contraceptive Prevalence Survey*, 1981.

younger age groups is attributed to the fact that the trend of increasing age at marriage for women has reached a ceiling at slightly over 23 years. Fertility declines among older groups are variously attributed to the extensive use of induced abortion and the rapidly increasing use of contraception.

However, meeting the goal of a further reduction in fertility rate is a much difficult task than any faced in the past years due to the various unfavorable socio-demographic factors including the impact of the 1950's post-war baby boom, traditional value of boy preference, increasing use of induced abortion, etc. In addition, there have been a lot of problems in contraceptive acceptance and its effectiveness such as high discontinuation rate of contraception and the delayed use of contraception for fertility termination. In order to cope with these increasingly unfavorable socio-demographic conditions and program problems, the national family planning program must review its past program implementation strategies. The program needs to be rationalized in several key areas in order to make it more effective and more efficient. One of basic program components that must be analyzed and redesigned is the program management system.

C. Program Cost

Recent analysis shows that program cost during the last 19 years (1962-1980) totaled about US$143.7 million. 81.2 percent of the funds came from the national and local governments and the remaining came through foreign assistance. Local governments have provided matching funds for salaries of family planning workers and maintenance costs for vehicles. More than two thirds of the total funds are spent on contraceptive services and family planning worker's salary support, including travel expenses (see Table 2).

The national expenditure for family planning in Korea has drastically increased in accordance with the ongoing expansion of the program. In 1962, the total program expenditure including foreign assistance was only US$0.6 million. This increased to US$16.9 million by 1980. Of the total program expenditure for that year, 90.1 percent was provided by the national and provincial governments and the remaining 9.9 percent by foreign donor agencies. The majority of the funds for 1980 were outlayed for contraceptive services (43.7%) and salaries of family planning workers (35.8%). Other

Table 2. Total Expenditure for Family Planning Program by Components: 1962—1980

Unit : Thousand US$

Components	Total Expenditure at Current Price	Percent (%)
Contraceptive Supplies	60,111	41.8
Information, Education and Communication	8,682	6.1
Payments for Family Planning Workers Including Travel Expenses	38,285	26.7
Training and Material Development	5,519	3.8
Pilot Projects, Research and Evaluation	9,671	6.7
Administrative Support	21,388	14.9
Total	143,656	100.0

Source : KIPH, *1980 Family Planning Program Evaluation Report*, October, 1981.

categories included IE&C activities (7.8%), training of program personnel and material development (2.7%), pilot projects and research/evaluation (4.1%), and other administrative support (5.9%).

In order to analyze the cost-effectiveness of the program, the total number of SCYP (Standardized Couple Years of Protection) and births averted were computed by using the SCYP methodology developed by Gorosh and Wolfers. It is calculated that a total of 8.9 million SCYPs were provided and 3.5 million births were averted during the 19 years, 1962-1980. The total expenditure of $143.7 million for the same period amounts to $16.08 per SCYP and $41.64 per birth averted. As shown in Table 3, a noteworthy finding is that the cost per SCYP and per birth averted have greatly increased in recent years. This is due to the increasing emphasis on female sterilization since 1976, the lower effectiveness of contraceptive use resulting from fertility decline, and general cost inflation (increased workers' salaries and physician contraceptive fees). In 1980, authorized private physicians were reimbursed by the government on a per-case basis—$2.20 per IUD insertion, $22 per female sterilization, $14.70 per vasectomy and $11.30 per abortion (menstrual regulation).

D. Program Personnel

As of December 1980, a total of 3,811 full time employees were engaged in the national family planning program (Table 4). They are primarily employees of four organizations, the Ministry of Health and Social Affairs (MOHSA), local governments under the Ministry of Home Affairs (MOHA), the Korea Institute for Population and Health (KIPH)[1] and the Planning Parenthood Federation of Korea (PPFK).

The MOHSA, which is responsible for overall planning, coordination and monitoring of the national program, has a total of 12 staff including 4 program managers, 2 family planning workers, and 6 clerical staff. Provincial, city, and county governments, which are responsible for the implementation and field operation of the program, employ 87 percent of the total program personnel, most of them being family planning workers. The KIPH, a statutory organization under the MOHSA, is responsible for the evaluation and research for the program. The KIPH employs 141 personnel. The PPFK, a

Table 3. Cost Per SCYP and Per Birth Averted: 1962—1980

Year	Total Expenditure* ($1,000)	Total Number of SCYP (1,000)	Total Number of Births Averted (1,000)	Cost Per SCYP ($)	Cost Per Birth Averted ($)
1962—1966	6,979	1,282	512.9	5.44	13.61
1967—1971	24,529	1.863	745.2	13.17	32.92
1972—1976	35,266	2.380	946.7	14.82	37.25
1977—1978	76,882	3.406	1,245.6	22.57	61.72
Total	143,656	8,931	3,450.4	16.08	41.64

Source : KIPH, *1980 Family Program Evaluation Report,* October, 1981.

* Total expenditure at current price in US Dollars included all sources of funds from the national and local governments and international donor agencies.

1) The Korea Institute for Population and Health (KIPH) was inaugurated in July 1981 as an integrated institution of the Korean Institute for Family Planning (KIFP) and the Korea Health Development Institute (KHDI). The KIPH is responsible for conducting research and evaluative studies related to the problems and systems in the fields of population and national health services.

Table 4. Number of Full-Time Employees in the National Family Planning Program

Program Units and Job Categories	National Level	Provincial Level	County/City Level	Total
Central Government (MOHSA)				
Program Managers	4	—	—	4
Administrative Supporting Staff	6	—	—	6
Family Planning Workers	2	—	—	2
Sub-total	12	—	—	12
Local Governments				
Program Managers	—	22	408	430
Administrative Supporting Staff	—	22	224	246
Family Planning Workers	—	65	2,548	2,613
Physicians (Mobile Vans & FP Centers)	—	31	—	31
Sub-total	—	140	3,180	3,320
PPFK				
Program Managers	1	—	—	1
Administrative Supporting Staff	53	117	—	170
Physicians (Demonstration Clinics)	—	15	—	15
Family Planning Workers (Demonstration Clinics)	—	16	—	16
IE&C Professionals/Information Officers	11	21	136	168
Sub-total	65	169	136	370
KIPH				
Program Managers	2	—	—	2
Research Professionals	72	—	—	72
Administrative Supporting Staff	67	—	—	67
Sub-total	141	—	—	141

voluntary organization, is the primary provider in the field of information, education, and communication (IE&C) activities for the program. The PPFK employs 370 staff at family planning demonstration clinics and information officers at the county level.

Out of 3,843 program personnel, 5.7 percent are located at the central level, 8.0 percent at the provincial level, and 86.3 percent are the city and county (health center) level or below.

Table 4. Continued

Program Units and Job Categories	National Level	Provincial Level	County/City Level	Total
All Employees				
Program Managers[1]	7	22	408	437
Administrative Supporting Staff[2]	126	139	224	489
Family Planning Workers[3]	2	81	2,548	2,631
Physicians (Clinical)	—	46	—	46
IE&C Professionals/Information Officers	11	21	136	168
Research Professionals	72	—	—	72
Total	218	309	3,316	3,843
	(5.7%)	(8.0%)	(86.3%)	(100.0%)

Remarks : 1) Program managers included Public Health Bureau Director and Chiefs of Family Health Division/Sections in the MOHSA, Director and Deputy Director of KIPH, Secretary-General of PPFK, Chiefs of Public Health Section/FP Sub-section in the Provincial Governments, and Directors and Chiefs of FP Sections of the Health Centers.

2) Administrative supporting staff included all categories of supporting personnel such as government officials in charge of FP program at all levels, clerks, key-punchers, drivers, guards, etc., at the KIPH and PPFK.

3) 2,631 FP workers consist of nurse/midwife (7.1%), nurse (22.3%), midwife (0.7%), and nurse-aid (69.9%).

Approximately 2,600, or about 69 percent of the total program personnel, fall under the category of family planning workers (nurses, nurse/midwifes, midwifes,and nurse aides). The great majority are assigned to health centers and from there dispatched to township offices to perform field activities, including home visits and group meetings for motivating and recruiting eligible couples. Field workers distribute condoms and oral pills, and refer IUD and sterilization clients to the designated family planning clinics. One of the main responsibilities of township family planning workers is the organization of mother's clubs, and their active maintenance. Currently, coverage is one family planning worker for every 4,200 eligible couples in urban areas, and one for every 1,200 in rural areas. In the every stages of the program, township workers were usually only high school graduates. After several years, however, they were developed into nurse aides with 9 months institutional training. Currently, the govern-

ment is preparing short term (4 months) midwifery training for the workers to expand their role in MCH service delivery.

E. Provision of Contraceptive Methods

Major methods for birth control available throughout the country in both the public and private sectors are the IUD, oral pill, sterilization for males and females, induced abortion through menstrual regulation and traditional methods such as condoms and foam tablets. Practically anyone who wants contraceptive services and get advice and care when desired. Contraceptive services in the program have been essentially free of charge except for the oral pill. Only very recently the program has started to charge a nominal service fee for condoms. For clients in remote areas, the program provides either mobile clinic services or transportation to reach clinics. For free clinical contraceptive services, clients receive coupons from field workers and mother's club leaders and then go to the designated clinics to get the services desired. Local health centers pay these clinics on the basis of redeemed coupons.

Between 1962 and 1980, a total of 1,107 million cumulative acceptors have received contraceptive services under the national family plannig program, as shown in Table 5.

Table 5. Program Acceptors by Methods, 1962—1980

Method	Year Started	Program Acceptors (1000's) 1962—1980	1980
IUD	1963	4,705.4	188.4
Male Sterilization	1962	470.0	28.1
Female Sterilization	1976	812.7	179.1
Condom*	1962	2,693.6	73.8
Oral Pill*	1968	2,142.9	102.8
Abortion (M.R.)	1974	246.8	70.2
Total		11,071.4	642.4

* Annual cumulative total users.

Source : KIPH, *1980 Family Planning Program Evaluation Report*, October 1981.

The number of annual program acceptors has steadily increased from 151,163 in 1963 to 842,159 in 1975, and since then it has maintained the range of 700,000 to 800,000. The IUD was the principal method of contraception provided by the program until 1976, at which time the government made female sterilization services available through the introduction of the laparoscopy and "minilap" methods. The popularity of female sterilization has increased very rapidly during the last few years. Out of 678,684 program acceptors in 1980, the proportion of female sterilizations and IUD insertions were virtually the same (27.9 percent and 29.3 percent respectively).

The contraceptive practice rate in Korea has steadily increased from 9 percent in 1964 to 55 percent in 1979 (Table 6). The number of contraceptive users who obtain supplies and services through the commercial sector has also been increasing yearly. In 1966 only 4 percent of the total was accounted for by users in the commercial sector, however in 1979, 25 percent was realized through commercial channels. Of the total number of married eligible women (age 15-44) in 1979, 21 percent had used contraceptive methods in the past but stopped for one reason or another, and 24 percent had never practiced contraception.

As shown in Table 7, a large proportion of condom and oral pill users obtain contraceptive supplies from drug stores and health centers, while the source of services for sterilization remains primarily the family planning-designated private clinics and

Table 6. Contraceptive Practice Rate by Method and Sector, 1979

Method	Government Sector	Private Sector	Total
Oral Pill	3.7%	3.5%	7.2%
Condom	1.6	3.6	5.2
IUD	9.0	0.6	9.6
Vasectomy	5.4	0.5	5.9
Tubectomy	9.8	4.7	14.5
Other Method	—	12.1	12.1
Total	29.5%	25.0%	54.5%

Source : KIFP, *1979 Korea Contraceptive Prevalence Survey*, 1981.

hospitals. Also, a large proportion of IUD insertions are performed at government health centers, since the loop is manufactured by the government and distributed only to health centers and family planning-designated clinics and hospitals. Considering the increase of condoms and oral pills obtained through the commercial sector, the government has recently emphasized the provision of sterilization services and de-emphasized its distribution of condoms and oral contraceptives.

F. Organizational Structure

The overall responsibility for the national family planning program is implicitly delegated to the Ministry of Health and Social Affairs, which has established a Family Planning Section in its Bureau of Maternal and Child Health. However, determination of the nation's population goals are made primarily in connection with the development of the total economic plan over a 5 year planning horizon. The agency responsible for this is the Economic Planning Board (EPB), which acts with the guidance of the MOHSA and other agencies. In turn, the MOHSA, in collaboration with KIPH, draws up program and

Table 7. Source of Contraceptive Methods by Provider and Method, 1978

Provider	Oral Pill	Condom	IUD	Vasectomy	Tubectomy	Other	Total
Health Center	50.5%	36.3%	54.3%	17.2%	7.0%	—	31.2%
Family Planning Designated Clinic/Hospital	—	—	26.8	62.1	52.3	—	29.6
Non-Designated Clinic/ Hospital	—	—	8.2	10.9	37.7	—	13.8
Drug Store	41.0	54.9	—	—	—	100.0	17.3
PPFK Clinic	—	0.6	2.7	5.2	1.8	—	1.9
Family Planning Mobile Van	—	—	8.0	4.6	1.2	—	2.9
Township Office	6.6	3.3	—	—	—	—	—
Other	1.9	4.9	—	—	—	—	1.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source : KIFP, *1978 Family Planning and Fertility Survey*, Dec. 1979.

activity targets for the field staff. These are then transmitted to the Ministry of Home Affairs (MOHA).

Because there is a lack of technical staff at the MOHSA to carry out management functions for family planning activities, technical and professional assistance for program implementation is provided by the KIPH and PPFK. The KIPH is responsible for program evaluation and research in the field of population and health, while the PPFK is responsible primarily for the program's IE&C activities and pilot clinical services. In view of their responsibilities, central management functions assigned to the MOHSA are implemented with staff support from the Research and Evaluation Divisions of KIPH.

The MOHSA is the link between the country's central and local goverments. There is a high degree of decentralization in this structure, with relatively tight control being exercised through a system of targets for most major programs, including the family planning program. These targets are passed through the MOHA to each provincial government, which retains flexibility in acting to fulfill the targets. At the provincial level, the structure is similar to the central government, with Bureaus representing most Ministries. Each provincial government has a Bureau of Health and Social Affairs containing a Public Health Section and a Family Planning Sub-section. At this level, there are medical and lay personnel who are responsible for supervision and certain administrative functions for the lower level health center network. However, within the provincial structure there is no locus of expertise for technical matters, which must therefore be provided from other sources, such as the MOHSA.

At the county and city level, health functions, including family planning services, are provided at the health center. The Health Center Director controls the health services network at the township level. Family planning field workers, for example, are supervised by health center family planning staff working under the Director. The township chief has little authority over the Health Sub-center physician although local health workers, including family planning, MCH, and TB workers, are directly under the town chief's control. His cooperation is generally essential for effective operations.

To summarize the organizational and management structure of the program, the Bureau Director of MCH, the Chief of the FP Section and two administrators as Chiefs of FP Sub-sections in the MOHSA, the Director and Deputy Director of KIPH, and the

Secretary-General of PPFK are "program managers" at the national level. At the provincial level, "program managers" are all Chiefs of Public Health Sections and 11 lay administrators who are Chiefs of FP Sub-sections. At the city/county/district levels, the program managers consist of 204 lay administrators who are chiefs of FP Sub-sections in the Health Centers. Usually, medical and paramedical personnel are specially recruited without any written civil service examination, while other lay administrators are selected through the civil service examination of the government. According to the Program Manager's Mail Servey,[2] 56.0 percent of the 384 respondents program managers were recruited by a special appointment process, while 31.3 percent were hired through the normal civil service examination process.

The results of the mail survey indicate that the program managers at central and provincial levels are well educated; twenty out of twenty-nine program managers had completed their college education and only one had less than a high school education. Although the educational level of program managers at the local level is not as high as that at the central and provincial level, the proportion of program managers who hold a professional license is much higher, as shown in Table 8. In short, the management of the national family planning program is primarily executed by medical, paramedical, and administrative personnel working at the local level.

The program managers at all levels are permanent government employees who are subject to rotation. Thus, program managers are rarely able to remain in the same position as long as desirable, even though the family planning program requires a considerable time period to gain the technical and managerial skills necessary. During 1979, there was a turnover rate of 48.3 percent among the program managers. This high turnover rate shortens the managers' length of time in their job and limits program effectiveness. However, these two problems have been minimized by emphasizing utilization of senior family planning workers who have been on the job for many years and have valuable program experience.

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2) For data collection of this paper, a mail survey was conducted in December 1979 by a well-administered questionnaire reaching 437 program managers at all levels. The respondent rate was 87.9 percent.

Table 8. Educational Experience, Licenses, Selection Process and Annual Turnover Rate of Program Managers

Category	Central		Provincial		Local		Total	
	n	%	n	%	n	%	n	%
Education								
Middle School	—	—	1	4.5	74	20.8	75	19.5
High School	—	—	8	36.4	121	34.1	129	33.6
College or More	7	100.0	13	59.1	160	45.1	180	46.9
Total	7	100.0	22	100.0	355	100.0	384	100.0
License Possessed								
Medical Doctor	1	14.3	5	22.7	125	35.2	131	34.1
Nurse/Midwife	—	—	3	13.6	32	9.0	35	8.1
Other[1]	—	—	4	18.2	27	7.6	31	8.1
None	6	85.7	10	45.5	171	48.2	187	48.7
Total	7	100.0	22	100.0	355	100.0	384	100.0
Selection Process								
Special Recruitment[2]	4	57.1	10	45.4	201	56.6	215	56.0
Normal Recruitment[3]	3	42.9	10	45.5	107	30.2	120	31.3
Unknown	—	—	2	9.0	47	13.2	49	12.7
Total	7	100.0	22	100.0	355	100.0	384	100.0
Turnover Rate for 1979								
Transferred	2	28.6	10	45.5	135	38.0	147	38.3
Leaving	—	—	1	4.5	37	10.4	38	9.9
Total	2	28.6	11	51.0	172	48.4	185	48.3

1) Other licenses included pharmacist, X-ray technician, veterinary doctor, etc.
2) Recruitment of program managers without any civil service examination is only for the posts of medical and other professional fields.
3) Recruitment of program managers through formal civil service examination.

Source : KIFP, Program Manager's Mail Survey on Family Planning Management Development in Korea, December 1979.

III. ISSUES AND CONCERNS IN RELATION TO MANAGERIAL PERFORMANCE

A. Overall Assessment of Program Operation and Management

Since the function of program management is to ensure that all component activities are effectively accomplished according to an adopted implementation plan, it is important to identify the true constraints limiting program effectiveness and to trace back the identified problems to specific management functions. In view of the relationship between program operations and management, current program strengths and weaknesses must be identified.

For many years, the program has had the basic characteristics of: a) service provision through a nationwide health network by full time family planning workers and designated private clinics under the responsibility of local administration, b) centrally-monitored annual acceptor targets, c) a built-in evaluation system with institutionalized training and research activities through the KIPH, d) flexible administration of IE&C activities and organized community support through the PPFK, and e) over-all planning and coordination community support through the PPFK, and e) over-all planning and coordination by the MOHSA and the central government.

The program has been providing contraceptive services to about 15 percent of the eligible couples every year and achieving fertility reduction goals quite successfully. Therefore, it is reasonable to say that the program has been working well, without serious problems, and that program management has generally been quite effective. However, there are areas of weakness and problems to be solved in order to increase further the efficiency and effectiveness of program operation. These problem areas include: a) rigid rural oriented program structure and rapid urbanization, b) high discontinuation rates of contraceptive usage and inadequate follow-up of acceptors, c) high turnover rate of field workers and poor personnel management, d) difficulties in the use of the local civil administration system and coordination with other health programs, e) poor quality of research and low utilization of research findings, f) weak management training, and g) poor relationships among special projects and between projects and the total program. A specific discussion of each of these areas are as

follows.

1. Rigid rural-oriented program structure and rapid urbanization

As mentioned in the section on program organizational structure, the family planning field worker/authorized physician system has been the backbone of the national family planning program. The initial reason for adopting such a strategy was to place greater emphasis on rural areas, based on the unequal distribution of urban/rural population (29:71). In the rural areas, where conditions are appropriate, this has been a powerful strategy, and remains essentially sound. In urban areas, however, the approach is not performing successfully. A strong effort is needed to develop a comprehensive new urban population strategy reflecting the characteristics of an urban setting.

2. High discontinuation rates of contraceptive usage and inadequate follow-up of acceptors

Within the existing FP program, discipline, responsibility, and emphasis on performance brings results, as it does in other activities. However, the emphasis is sometimes misplaced, with a lack of attention to follow-up and continuance, and the result is that the achievements of the field staff do not pay full dividends. Without adequate continuation maintanence, the program eventually reaches the stage where a great deal of activity is producing very little progress. According to the Contraceptive Acceptors' Follow-up Survey, only 23.8 percent of all the acceptors were followed up at home or returned to health centers for consultation on side effects. This situation is due to the fact that the family planning program has in the past emphasized recruitment of new acceptors to the exclusion of other activities, including follow-up. There are acceptor targets but not follow-up or revisit targets. The lack of concern with follow-up is the major contributory cause to low continuation rates of IUD and oral pill users in Korea.

3. High turnover rate of fieldworkers and poor personnel management

Another specific weakness in the field worker/authorized physician system includes the high turnover of field workers and consequent low average level of experience on the job. According to the program management survey, the turnover rate of family plan-

ning workers was 24.3 percent during 1979. The high turnover of field workers has led to a continual demand for more training, and constitutes a serious constraint on program performance. Survey data revealed that 25.6 percent of the health center FP workers and 37.0 percent of the township had not received any substantial training in family planning. The high turnover rate is attribution to the demanding nature of the job relative to compensation and other available opportunities.

4. Difficulties in the use of the local civil administration system and coordination with other health programs

A significant strength of the program is the cooperative activity possible and normal among different agencies, based on a predetermined plan. The MOHA, for example, works effectively to fulfill the requirements presented to it by the MOHSA. The associated weakness, however, is that the limited ability to centrally monitor the activities of these various agencies generally results in a lack of flexible interim cooperation in solving newly emergent problems. At the same time, the use of the MOHA network of health centers must be considered a strength of the program. The MOHSA is simply not equipped to independently operate a massive field program, and, in fact, the present MOHSA central-to-local chain of command is recognizably inefficient. Moreover, gaps in day-to-day communication and coordination make it difficult to solve the MOHSA's family planning problems solely through adjustments in the MOHA's health apparatus. These again are amenable to improvement through management activity.

5. Poor quality of research and low utilization of research findings

From the beginning of the program, research and evaluation have been outstanding features of the national effort, particularly in terms of output evaluation. However, serious problems exist in the diversion of major program resources away from directly relevant, responsible, and action-oriented studies to those of program management. Moreover, there is a need for improved feedback to and action by policy makers and program administrators to solve specific problems. Obstacles that prevent the research and evaluation findings from being rapidly fed back into the program include: 1)

academically creditable but only indirectly applicable findings, 2) limitations in manpower and time of program managers and administrators, 3) irrationality existing in program planning, and 4) short job tenure of program managers due to personnel management problems. As a part of the program control functions, a comprehensive system of records and reports has been a substantial asset. Critical weaknesses remain, however, in the questionable quality of much of the recording and reporting, as well as the limited ability of using these records and reports effectively at the supervisory and central level.

6. Weak management training

A variety of training courses for program personnel have been provided through the KIFP, the most critical being those for field workers, authorized physicians and supervisory personnel. While the content of training is modified and adjusted on an ongoing basis, the system must be made to use this resource more effectively to further develop field worker, physician, and supervisor skills. This is again largely a problem of coordination and planning.

7. Poor relationships among special projects and between projects and the total program

There has been little attention to the management of individual sub-programs or projects done outside the planning process, which is more oriented toward identifying program components with evaluation of results and costs. Since the inception of the national family planning program in 1962, the government has strengthened and expanded the program by launching numerous special projects, such as the urban-low income area project, the hospital project, the industrial site project, the IE&C project, etc., all of which are essential parts of the urban family planning program. Each is regarded as a discrete program, however, without a conscious attempt to manage these programs is in a coordinated fashion, major wastage of resources is likely to occur. A prototype project management system has yet to be developed.

B. Quality of Program Management Functions

Despite extensive program activities, Korea still has a modest contraceptive usage

rate, a low continuation rate, and a low effectiveness of contraceptive use due to the late age at which many women start practicing birth control. Contributing to these problems has been less-than-efficient program management, particularly as it relates to program planning; control, coordination, evaluation, supervision, and management information systems. The program has been operated without well-coordinated usage of modern management skills and techniques and has mainly depended upon a program management activities in use since the program's beginning in 1962. Those management activities, their current status, and the opportunity for strengthening them will be reviewed:

1. Program planning

The content of the family planning program is primarily determined by demographic goals included in long range economic development plans. Although an attempt is made to translate overall demographic goals into an estimate of the births that must be prevented, the leap from there to the activities which will do the job is still enormous. Recently, computer-based methodology for target setting has been introduced through TABRAP, a program which allows demographic goals to be converted into contraceptive acceptance targets. However, there are difficult methodological problems in utilizing such a method in Korea as elsewhere.

At the beginning of each calendar year, the MOHSA decides how many new acceptors of each contraceptive method (IUD, sterilization, condoms, oral pills) must be recruited during the coming year. Factors considered in the target setting include nation-wide fertility goals, program achievement in the previous year, budget allocations, and proposed targets submitted by the provincial governments.

Once the numerical targets have been set at the national level, they are apportioned among the provinces; at the provincial level the quotas are divided among the counties and urban wards so that each health center receives its own quota for each contraceptive method. The primary criterion used in the allocation of the targets is the size of population of eligible married women, aged 20-44, although at the county level targets are adjusted somewhat to reflect the previous year's performance.

As in other government programs, the administration of the family planning pro-

gram is characterized by emphasis on target achievement. The strengths of the target system in Korea: 1) allow program managers to translate demographic goals into required field services, and, therefore, to prepare realistic program budgets, 2) allow realistic assessment of the ability of the current program to meet the goals, and thus provides a basis for future planning, 3) apply a certain amount of pressure at all levels in the government structure to achieve the targets, and 4) provide a concrete basis for monitoring program performance through the monthly service statistics system. However, it is urgent to develop a better index for the target system in order to reflect continuation rates. This needs to be done to direct the attention of field workers to the importance of follow-up and maintainance of acceptors. In addition, target-setting methodology should be improved in order to more appropriately monitor the achievement of national demographic goals from specific operational targets.

In summary, the quantitative target system has been extensively applied to the management of the family planning program in Korea at all levels. The target system serves as a guide for evaluating program performance in aggregate terms. Korea's family planning program is conceptually separate into the primary functional categories of 1) contraceptive services and supplies, 2) field workers' salaries and travel expenses, 3) information, education and communication, 4) pilot project, research, and evaluation efforts, 5) training of program personnel, and 6) administrative support. However, program planning is not geared towards specification of activities and tasks but simply towards stating objectives and targets. The elaboration of specific activities are omitted from the planning process and left to the implementation stage. Therefore, current program planning is too limited to serve as a guide to program managers for the monitoring of current operations except in the area of target achievement under their direct responsibility. Poor specification of family planning program activities in the planning stage has provided very little guidance for the program managers in management planning, monitoring and evaluation.

2. Resource allocation

a) Financial resources and budget allocation

One of the important elements for successful implementation of a family planning

program is adequate financial and budgetary planning. Recognizing the country's possible population crisis, the Korean Government has given priority to family planning as an integral part of the National Economic Development Plan. Financial resources for the program have been mobilized from government budgeting as an item in the Economic Development Special Account, which reflects primarily government-sector involvement in economic development. The budget for the family planning program rapidly increased from 1962 to 1979, as compared with other health budget items.

The task of developing annual budgets and mid-year budget adjustments is a complex process. The MOHSA prepares the central budget for family planning, largely a clerical function, given independently arrived at policies on targets, salary levels, doctors' fee, etc. Each other agency prepares its own budget, with the MOHSA and the EPB involved in the allocation of the large program budget items used in many different program activities. However, it is extremely difficult to pull these diverse budgets sources together into a coherent and comprehensive picture. Thus, systematic analysis of program strategy has to form the basis for improving the process of resource allocation within the program. This vital area is now being handled on an essentially *ad hoc* basis, with important questions of emphasis and priority seen only as clerical considerations without scrutiny of their contribution to the overall program or cost-benefit.

b) Nursing corps and field workers

Another major resource is program manpower; field workers and designated clinic physicians. Currently a total of 2,600 family planning field workers are working at the city and county health centers and township health sub-centers in the country. Under the current program administration system, these field workers are hired, transferred, and dismissed under the jurisdiction of the respective local government head. The central government (MOHSA) has the authority, however, to establish personnel policies governing matters such as minimum qualifications for appointment (e.g., nurse or midwife for health center workers, nurse aide for township field workers), and standardized job descriptions. The high turnover rate of field workers and resultant low average level of job experience have been serious constraints on program performance and training capacity. According to 1979 data, gathered by the KIFP, the average family planning worker does not yet fit the ideal — mature, married, experienced and highly trained —

as shown in Table 9.

Table 9. Family Planning Workers' Characteristics, 1979

Characteristics	Percent Distribution
Age Over 25 Years Old	78.7[1)]
Married	58.2
Length of Service Less than One Year	28.8[2)]
Nurse or Midwife Licensed	30.6
Nurse-aid Certificate	68.4
High School Education or More	75.6
Basic Family Planning Training Course Received	67.4
Refresher Training Course Received	39.0

1) Average age of all workers is 31.
2) Average length of service of all workers is 3.1 years.

Source : KIFP, *Family Planning Workers' Central Registration System*, 1979.

c) Provision of training

Although the high turnover of field workers could be lessened through better compensation or permanent employment status, the most important thing to improve is the quality of the field workers through extensive training programs. Training courses currently offered by the KIPH are classified into two groups: 1—2 week lecture-type training courses for field workers, and 2—3 day orientation courses for provincial staff, township chiefs, provincial and county administrators, health center directors, and other staff members. Areas covered include IE&C strategies, clinical technqiues, population problems, basic techniques of supervision and evaluation, and general administrative procedures. According to the latest data (shown in Table 9), only 39.0 percent of workers have participated in refresher courses. Because of the heavy training load to provide basic training for newly-recruited field workers, KIPH has not been in the position to carry out periodic refresher courses for many years. An increase in the number of trainers and training facilities is greatly needed.

d) Use of private clinics and mobile vans

Another important manpower resources are the 2,300 private physicians who have

been trained, authorized, and paid a fee by the government to provide contraceptive services to eligible couples. Any private doctor can apply to become an authorized physician. If his or her application is accepted, he or she is sent to the KIPH or the Korean Association for Voluntary Sterilization (KAVS)[3] for specific training. Upon successful completion, he or she is then authorized to participate in the family planning program. Authorization is at the discretion of the provincial government, and the MOHSA is informed of all actions taken. Although mobilization of private physicians has been a crucial factor in the successful implementation of the program, inadequate services in rural areas still exist. According to a survey done by KIFP in 1978, 58.6 percent of the total 1,454 townships in rural Korea had no authorized physician. In order to remedy this situation, the government has re-emphasized utilization of the existing 15 family planning mobile vans to help deliver clinical contraceptive services in the rural areas. These mobile vans have not been able to operate effectively, however, due to a variety of difficulties, including recruitment of well-qualified doctors, inadequate financial support for maintenance and operation, and inadequate coordination with other field activities.

e) Use of para-medical workers for IUD insertions

As a part of the effort for solving the manpower shortage problem mentioned above, the government has trained and utilized nurses for IUS insertion since 1974. The Maternal and Child Health Law allows nurse and mid-wife to insert IUD upon completion of a 60 day training course provided by the Government. A total of 322 para-medical personnel were trained in Korea during the period 1974—1980. The loop acceptors' follow-up survey has revealed that 37.0 percent of the total loop acceptors done during 1976—1978 was inserted by this group. A continuing problem has been the absence of follow-up after completion of the training program, again basically a personnel management problem.

3) The KAVS, established in 1975 as a voluntary organization, has responsibility for the provision of training courses for designated physicians, treatment of complications and side effects from sterilization, and provision of technical and logistical support for the operation, repair, and maintenance of sterilization equipment.

3. Coordination

Implementation of the national family planning program demands close coordination and cooperation among public and private institutions. This is broadly classified into interministrial and interagency coordination.

a) Interministrial coordination

In 1963, in the early stages of the program, a Family Planning Encouragement Plan was formulated and issued. This plan included action by the ministries to encourage wider exposure for the family planning program. According to the Prime Minister's instruction, all ministries and their affiliated offices were ordered to compile long-range family planning strategies and to include these in their own activities in establishment of the Population Policy Council (PPC), comprised of Vice-Ministers in ministries related to population and family planning. It was placed under the control of the Deputy Prime Minister as one of the priority projects among government programs. With the MOHSA busy in expanding the national family planning program, the PPC had no full time secretarial staff and the impact of the Prime Minister's instruction lasted only a few years, with little innovative activity resulting.

In the middle of the 1970's, a few ministries became more active in population planning actitivies, for example, there was a revision of school curricula on population education (Ministry of Education), promotion of family planning service through the military establishments (Ministry of Defense), development of industrial site family planning proejcts (Office of Labour Administration), encouragement community participation through the New Village Movement (MOHA), development of measures against rapid urbanization (Ministry of Construction, Seoul City). The MOHSA and the EPB also realized that attainment of the Fouth Five-year (1977-1981) program goal had become unlikely due to socio-demographic factors. In 1976, to re-activate interministrial coordination, the government established a new Population Policy Deliberation Committee (PPDC), which is a reformed and upgraded PCC similar to that which existed in early 1960s. The current PPDC consists of seven ministers, three minister-level officials and three experts in the population field. It is chaired by the Deputy Prime Minister, who is also the minister of the EPB. The PPDC is supported by a working committee and full-

time secretariat from the EPB. Since 1976, the PPDC has met once and the working committee has met three times. The effectiveness of such a high level committee depends upon the initiative of the secretariat, whose adequacy is difficult to determine at this stage.

b) Interagency coordination

The MOHSA is in charge of overall planning, coordination and implementation of the national program which includes matters of interagency coordination. Under the direction of the Ministry, the KIPH has responsibility for the research and program evaluation. The PPFK has responsibility for the IE&C component of the national program and support of the nationwide system of family planning women's clubs. This arrangement enables delegation of responsibility to the participating agencies which takes advantage of their particular strengths and minimizes overlap and duplication. The coordination between these agencies has been smooth; however active coordination must be maintained in order to avoid conflicts and to provide full information to the MOHSA for proper program planning, implementation, and evaluation. To encourage this, quarterly meetings and program evaluation seminars are regularly held at the KIPH with attendance of representatives from the different agencies. While the KIPH is active in promoting technical coordination, it is also desirable for the MOHSA to play a more active role in policy coordination through the establishment of a formal committee. An official and broader coordination mechanism is needed to actualize the concept of integration of family planning with MCH and primary health care services.

4. Program Supervision

Technical supervision and control over the whole process of program operation is formally contained within the MOHSA. To make the supervisory function effective, the government has organized and operated supervisory teams at each unit level of the family planning program (central, provincial and local).

The central supervisory team consists of staff personnel from the MOHSA, KIPH and the PPFK. At the provincial level, supervisory nurses are assigned by the FP Subsection Chief in the Public Health Section. At the county level, each health center has at least one senior FP worker, who functions in a supervisory/administrative capacity.

These personnel are crucial to the effectiveness of the program, and are the only regular communication link between the central government and the field other than formal reports and occasional field trips by the central staff. However, as yet no effective way has been found to fully utilize these personnel. The nature of the supervisory problem can be summed up as 1) the central supervisory team is inactive, 2) the provincial and county supervisors are not trained in supervision, 3) there are no supervisory forms and thus there is little accountability in supervision, and 4) there is no manual of supervision nor formal or informal supervisory procedures and instructions. The recent mail survey reveals the main supervisory styles of these personnel. Routine supervision is the most common style, followed by an "opportunistic style" (i.e., a provincial supervisory nurse paying a supervisory visit to a local health center if she happens to be visiting in the area for some other purpose). Non-supervision is also common (see Table 10).

Routine supervision is not an efficient use of limited time and "opportunistic" supervision or failure to supervise at all are obviously not effective ways of dealing with

Table 10. Supervisory Methods by Position of Supervisor

Supervision Methods	Provincial Supervising Nurse	Health Center Family Planning Sub-section Chief	Health Center Senior Worker
Routine Supervision of all Units According to a Preestablished Plan	59%	46%	60%
Regular Supervision of Problem Areas Only	—	5	13
Irregular Supervision of Units As the Opportunity Presents Itself	12	27	18
Do Not Supervise At All	29	21	10
Total (N)	100 (17)	99* (117)	101* (167)

* Does not add to 100 percent due to rounding error.

Source : KIFP, *Systems Analysis and Information Assessment of the Korean National Family Planning Program*, December 1978.

problems.

Table 11 shows the areas of observation in supervisory visits. Broadly, they fall into two groups; field worker activities and managerial activities.

Issues of greatest concern to provincial supervising nurses include poor program performance by field workers and inadequate administrative practices by lower level managers. Health center sub-section chiefs are concerned about worker's activities, the activities of senior workers, and reasons for poor target achievement. Senior workers concentrate on field worker activities, especially acceptor follow-up and record keeping, and on poor target achievement and logistic management of inventories.

Only a few items were mentioned by more than 20 percent of the respondents. This low freuqency is partly due to the fact that the questions were open-ended rather than forced-choice. However, it is apparent that there is very little agreement as to the specific activities requiring supervision.

5. Records/Reporting System

One of the crucial elements in the successful implementation of the national family planning program in Korea is the system of service statistics, which provides information for daily work planning, supervision and program evaluation. The service statistics system contains three types of instruments — records, coupons, and reports. It consists of 17 officially-designated record and reporting forms and a large number of unofficial record forms developed by local program managers.

The official record forms are kept for local administrative and managerial purposes. Their functions are 1) to help field workers plan their daily activities, 2) to help the supervisory personnel review in detail the activities of the field workers, 3) to record and store data that is subsequently transferred to monthly reports, and 4) to facilitate acceptors' management. In addition, a number of unofficial record forms have been designed by provincial and local program managers to augment the official records, which focus exclusively on acceptors. The unofficial record forms range from evaluation check lists to lists of the eligible population in a given area. The greatest number, however, are concerned with monitoring the daily activities of field workers, mobile vans, follow-up visit personnel, etc.

Table 11. Items Examined or Discussed in Supervision by Position of Supervisor

Contents of Supervision	Provincial Supervising Nurse	Health Center Family Planning Sub-section Chief	Health Center Senior Worker
(N)	(18)	(142)	(179)
Survey of Family Planning Target Population	22.2%	3.5%	7.8%
Reasons for Poor Achievement	55.6	23.9	27.4
Workers' Activities	61.1	50.7	49.7
Administrative Capacity	38.9	20.4	28.3
Accuracy of Reports and Records	22.2	11.3	18.4
Follow Up of Acceptors	27.8	10.6	21.8
Management of Complications	—	2.8	9.5
Logistic Management (Inventories)	44.4	14.1	20.7
Mobile Van & Urban Clinic Management	—	2.8	7.8
Supervision of Family Planning Authorized Clinics	33.3	6.3	7.3
Management of Mothers' Clubs	22.2	5.6	10.6
Maternal Child and Health Service	—	2.8	6.7
Supervision of Family Planning Worker	—	2.1	3.4
General Health Services	—	3.5	4.5
Management of Urban Slum Clinics	—	2.1	9.0
Program Management for Remote Areas	—	—	3.4
Budget Expenditures	5.6	—	—
Other	5.6	1.4	—

Source : KIFP, *System Analysis and Information Needs Assessment of the Korean National Family Planning Program*, December 1978.

Family planning coupons and reports, unlike records, flow upward from level to level through the government reporting channels. The following table isolates the reporting

system of the core agencies of the national family planning program; MOHSA, KIPH, and provincial county and township programs.

Table 12. The National Family Planning Program Reporting System: Reporting Agencies, Reports Prepared and Paper Flows

Program Agencies	Reports Prepared	Number of Copies Prepared	Number of Copies Submitted	Submitted To	Date of Submission
Township Health Sub-Centers	Family Planning Program Status Report	2	1	Health Center	1st Day of the following month
Health Center	Family Planning Program Status	3	2 (Attached each individual reports)	Provincial Gov't KIPH	5th day of the following month
	Coupon	2	1(A)	KIPH	
City & Provincial Government	Family Planning Program Status Report	3	2 (with attached reports)	MOHSA KIPH	10th day of the following month

a) Acceptor's coupons

The family planning coupons, sent directly to the KIPH from the health centers, serve to 1) measure progress towards meeting clinical acceptor targets classified by method, and 2) provide KIPH with information on the demographic characteristics of aceptors. KIPH uses the coupon data for such purposes as national or regional target setting and computer simulations of the effects of the national program on overall fertility. A complete tabulation of the coupons has been done quarterly since 1970 in order to get information on the changing composition and characteristics of FP aceptors.

b) Monthly reports

Monthly family planning progress reports are prepared by township health sub-centers, county health centers and provincial units, and are submitted to the MOHSA and KIPH. The purpose of the reports is 1) to inform higher levels of the progress made

at lower levels in achieving assigned acceptor targets, 2) to inventory contraceptive supplies for logistics management and to report service fees collected for pills and condoms distributed, 3) to report personnel levels and vacancies, 4) to keep track of the number of designated physicians active in each township, county, and province, and 5) to monitor the movement and qualifications of national program staff. The township, county, and provincial progress reports use essentially the same form. The county report is, with only a few additions, an aggregate of the county data. Consequently, the performance of individual service delivery points, such as clinics and township field workers, is known only at the county level. That is, the province receives county-level data only and MOHSA receives provincial-level data only.

c) Feedback

KIPH processes service statistics information into reports that are returned to the MOHSA, provinces, health centers, and other program agencies. Several evaluative indicators, such as target achievement by method, number of acceptors per field worker, CYP per thousand eligible women in a given area, etc., are used in the reports sent to program agencies. These reports make it possible for provincial and health center managers to compare the performance of 1) their province with other provinces, 2) the health centers in their province with each other, 3) the health centers in their province with other health centers in the same stratum, and 4) current provincial and health center performance.

d) Problems

Although the current record/reporting system has served a useful managerial purpose at each level, the system does not completely meet the needs of the program. The first problem is the quality of the basic records found at the local level. Little attempt is made to delete from the records those who have dropped out of the program, although at the same time there is no evidence of wide-spread over-reporting. However, there is very little checking done to ensure that records and reports are accurate. The result is that program managers are not sure how much they can rely on the information supplied them. The second problem is that field workers face an excessive administrative burden in maintaining all the required records. A great deal of data must be gathered, and there is occasional duplication and overlap between various reporting forms. Final-

ly, particular areas within the program are becoming increasingly important, such the IE&C program, the urban program, and the industrial site program. It is, therefore, important to have reports which spotlight the performance of each of these programs. Along the same line, the existing reporting system should be made a more useful tool for supervisory personnel in their job of monitoring and guiding the field staff.

6. Program Evaluation

Program evaluation activities have been an integral part of both the supporting and control functions of the national family planning program. Data necessary for concurrent and periodical program evaluation are obtained through the family planning service statistics and nationwide sample surveys. Program evaluation activities in the past have been directed toward public response to the program, primarily in the communication of knowledge of family planning methods and in the distribution of contraceptives. Program evaluation has thus focused on the effectiveness of the program in terms of changes in fertility behavior and changes in attitude toward, and knowledge and practice of, family planning methods. Accordingly, program evaluation has come to rely almost entirely on sample surveys rather than on service statistics, reports, and records. Nationwide fertility/KAP surveys have been conducted on a regular basis at two or three year intervals since the beginning of the program.

The above approach to program evaluation has resulted in part from the fact that the program managers have never articulated their information needs. Under these circumstances, decisions about what data were to be collected, and how these were to be aggregated and distributed, was based on the needs of the program researchers, rather than on managers. Therefore, the current evaluation and supporting service statistics system has provided a rich source of data for family planning researchers, but is poorly adapted to the needs of program managers. Many of the management problems of the national family planning program may be traced to this inadequacy.

The "target-performance" evaluation technique, which is commonly used in the various program units, appears to be inadequate for the program. When evaluation results in a given area show poor performance, the current system gives the program manager almost no help in understanding the reason. Program evaluation and supervi-

sion activities need a closer relationship, and the reporting system also must be strengthened to be more useful for supervisory personnel and program managers in their job of monitoring and guiding the field staff.

In summary, the current program evaluation system does not meet the needs of the program, particularly regarding program management. A managerial evaluation system has to be concerned with all components of the organization, including detection, diagnosis, prescription, and implementation. However, current program evaluation concerns itself more with the detection component to the relative neglect of other aspects. It stops at a description of problems and does not identify possible alternative corrective actions. The implementation of the managerial evaluation system in Korea is difficult due to 1) a lack of knowledge regarding information needs of the program managers at the various levels of program activity, 2) a lack of knowledge and techniques on the part of program managers to use such information as the basis for decision-making, and 3) a considerable and perceptable gap between program evaluation personnel and planning/management personnel.

In improving the evaluation processes, particular care has to be given to key areas such as training. Unfortunately, the training of program personnel in the use of evaluation outputs has been neglected in the national family planning program. The efforts needed to train program personnel in the use of evaluation will be a major factor in getting the system to work, particularly at the provincial and local levels. At the same time, the current service statistics system should be revised and strengthened to better meet the needs of the managerial evaluation system.

C. Quality of Program Managers

The successful implementation of a family planning program depends largely on efficient operational and managerial capability of the program managers at different levels.

Program managers in Korea are commissioned civil servants and have eight years average length of experience in civil administration. The average manager has gone through 4-5 weeks service training in public administration, including the principles of management. Therefore, managers in general are acquainted with administration and management techniques prior to assuming their duties in any of the civil services,

Table 13. Program Manager's Quality and Managerial Proficiency

Categories	Provincial Managers		County and City Managers	
	Number	Percent	Number	Percent
Length of Civil Service				
0-8 Years	—	—	101	28
8-15 Years	4	18	80	28
16+ Years	18	82	174	49
Total	22	100	355	100
Length of Current Position				
0—1 Year	8	36	166	47
1—2 Years	3	14	47	13
2—3 Years	2	9	25	7
3+ Years	9	41	117	33
Total	22	100	355	100
Family Planning Training Course				
Received	15	68	189	53
Not Received	6	27	125	35
Unknown	1	5	41	12
Total	22	100	355	100

including health and family planning. The program has been able to maintain a certain level of managerial efficiency even though turnover has been high. Regarding specific figures, as of December, 1979, 27 percent of the provincial-level managers and 35 percent of the county-level managers had not yet received KIFP's training courses in population and family planning. However, 86 percent of the provincial-level manager and 65 percent of the county-level managers responded that they felt sufficiently aware of the basic knowledge of population problems and family planning concepts.

Reviewing activities pertaining to field supervision in 1979, the frequencies of field supervisory trips were widely distributed, mainly due to variability of travel funds. Only about one third of the program managers made trips more than 11 times during the year.

Table 13. Continued

Categories	Provincial Managers		County and City Managers	
	Number	Percent	Number	Percent
Knowledge of Population/Family Planning				
Mostly Know	19	86	231	65
Partially Know	1	5	83	23
Almost Don't Know	—	—	4	1
No Response	2	9	37	11
Total	22	100	355	100
Number of Field Supervision during 1979				
1-10 Times	7	32	90	25
11-20 Times	5	23	51	14
21+ Times	2	8	100	28
None	3	14	60	17
No Response	5	23	55	16
Total	22	100	355	100
Decision Making Process				
Decides by Himself	—	—	7	2
Discusses with Subordinates	20	90	293	83
Delegates to Subordinates	1	5	17	5
No Response	1	5	38	10
Total	22	100	355	100

The decision making processes involved in program implementation includes discussion of the matters of concern with relevant subordinates. The survey further indicated that satisfactory coordination was maintained with other related organizations and agencies at both the provincial and local levels. Managers rely heavily on administrative guidelines from the Central Government as far as program administration and management matters are concerned. There is a tendency to maintain this traditional and stereotyped management system due to a lack of knowledge and techniques in modern management and program operation. The survey revealed that 90 percent of the provincial level managers and 84 percent of the county level managers felt a need to have additional management training.

The three-day long training course for program managers currently available at the

Korea Institute for Population and Health is mostly focused on knowledge of population problems, family planning concepts, and contraceptive methods. There are, however, limitations in supplying knowledge, attitudes, and skills regarding management which reflect the needs of program operation in the field. Considering the high turnover rate of the program managers, the level of training in the family planning program management to be provided by the KIPH is an important question still to be determined.

D. Major Management Problems Identified and Prerequisite Actions Needed

As mentioned earlier, the management system of the national family planning program, which up to now concentrated primarily on the delivery of family planning services in rural areas, has not significantly changed since its inception in 1962. Because of the economic development, modernization, and explosive urbanization in Korea during the last decade, the current system of managing and operating the family planning program seems no longer adequate to achieve the stated demographic goals. Among the management problems which have been encountered during the last few years are 1) lack of coordination and cooperation in planning and implementation 2) inadequate planning and target-setting techniques, 3) inadequate supervision and motivation of workers, 4) inadequate management information systems dealing with program evaluation and managerial decision-making, and 5) inadequate management skills of program managers at each level of the program.

Discussions between the government (MOHSA) and the KIPH have recently focused on the urgent need for improved management of the national family planning program. The vital question was how to improve overall program performance. In response to this, several research projects designed to answer this question have been developed and implemented. Of these management study projects, two have been directly concerned with better program management. The purpose of the first study project, which is scheduled to be completed in 1980, is to replace the existing service statistics system with a broader management information system (M.I.S.). The specific goals of the first project are: 1) to improve the management of the national family planning program, 2) to make the overall evaluation system of the national program more responsive to

managerial needs, 3) to modify the service statistics system so that the information it contains is more useful to all levels of program personnel, 4) to provide program managers with information at regular intervals that will help them monitor program effectiveness, efficiency, capacity, and quality, 5) to simplify existing forms and records so that reporting and record keeping is made less time consuming and difficult, and 6) to train program personnel in managerial techniques based on the use of the M.I.S. The purpose of the second study project is to develop a new target system in order to strengthen and improve program quality and performance. Currently, targets are set without consideration of demographic factors and the particular socio-cultural characteristics of the area and field workers often motivate eligible couples to accept inappropriate methods in order merely to achieve the assigned target. This system has resulted in poor service statistics and high discontinuation rates.

Work on program management, such as program planning, monitoring, and controlling, has involved both the MOHSA, which is responsible for this activity, and the KIPH, which has the resources to provide much of the support. However, the urgent task for the immediate future is to increase the capability of the program's own administrators and managers to identify, attach priorities, and solve the problems themselves.

IV. PROGRAM MANAGEMENT DEVELOPMENT ACTIVITIES

Efforts have been made toward achieving efficient management of the family planning program in Korea. Management development activities employed in the early stages of family planning in Korea included: 1) the provision of an annual program operational manual to be used by family planning program personnel placed in different levels of the service network, 2) holding an annual family planning evaluation seminar, and 3) providing short term training courses for family planning program personnel.

Stipulated in the annual program operational manual are matters pertinent to 1) unit program planning and analysis, 2) personnel management and training, 3) personnel task and assignment content, 4) recording and reporting, 5) budget planning and execution, 6) provision of contraceptive services and management, 7) IE&C activities, 8) surveys and evaluation, 9) operation of mobile vans and supervisory teams, and 10)

management of designated clinics and operation of the Woman's Association.

Since all family planning personnel are instructed to implement the program according to the manual, it has been possible to have consistency in program operation and a standard set of criteria for program managers who are controlling, monitoring and supervising the program at both central and field levels.

This manual, annually revised and supplemented to include changes in the program, is regularly disseminated along with MOHSA official directives to all program managers. Because the manual is comprehensive and up-to-date it is considered an essential tool in the family planning program.

One regular event which has played an important role in improving program management in Korea is the recurrent family planning evaluation seminar held since 1964. The evaluation seminar is attended by various program managers and family planning personnel from city, province, and local health centers. It is designed to upgrade managerial capability through an extensive evaluative analysis of the program performance and an exchange of practical experiences and problems faced in the previous year. It is usually held annually although it was held twice a year during the program initiation period from 1964 to 1968.

Since 1965, the Government has also offered short-term observational training for program managers and family planning personnel to learn family planning program management in other countries under the auspices of foreign donor agencies. The goal has been not only to promote personal capacity for program management, but also to infuse a positive sense of participation in the program. One-to-two week long observer training courses visiting several countries, such as Japan, Taiwan, Hong Kong, and Philippines, has received enough attention that it has interested aspiring program administrators and managers and has motivated their involvement in the program. The short-term observer courses, however, are not able to cover the whole number of demands during the time allowed due to budgetary constraints from the donor agencies. Joining the observational courses has been treated as an incentive and reward to the selected program personnel.

As a means to eliminate training problems, the Korean Government organized a 3-day basic training program in 1971, conducted at the KIPH. The primary emphasis in

the curriculum is to replenish the basic knowledge of the fundamentals of population and family planning for the chiefs of health of city and provincial governments, family planning sub-section chiefs, directors of health centers, and sub-section chiefs of health centers. Excessive emphasis on supplying basic knowledge in population and family planning has created notable lacks, however, in the technical and managerial aspects of program administration.

Moreover, nation-wide program evaluation has been conducted to a great extent around the role of the central government. The main evaluation activity has been to assess overall program effectivenss from the demographic aspect, rather than the managerial and administrative aspect of the program.

Based on the above, new development of a technical training course for program managers and administrators at different levels was seen as urgent in order to provide them with more systematic knowledge in program planning evaluation, and supervision, essential for their job performances in the field. This technical training was needed most for assisting lower level program managers in setting targets, recording and reporting various data, and other supervisory functions.

With these considerations, in 1973 the KIFP conducted a two-month long technical training on "Fertility and Family Planning Evaluation" under the financial assistance of ESCAP. In 1975, WHO supported a month-long training under the theme of "Family Planning Evaluation". There were 45 participants at KIFP from city and provincial supervisors to health center senior workers. Another ESCAP-assisted pilot training course was organized at KIFP in 1976 for 50 program managers from various different levels of management.

In.1978 and 1979, reserach utilization seminars were held at the KIFP. In addition to these seminars, quarterly program managers meetings are currently held to review current problems and to insure rapid feedback of research and evaluation findings into program formulation. In 1979, a two-day long seminar was held at KIFP, with 30 participants consisting of supervisors and senior workers. The primary emphasis was placed on exploring possible means to intensify supervisory functions in the programs at city, provincial, and county health center levels.

Brief examination of the contents of the curricula of regular training courses current-

ly available at the KIPH reveals that they deal with very few subjects relating to program management. Therefore, new development of courses designed to provide basic knowledge and skills regarding program administration and management is urgently needed at the KIPH.

V. FUTURE DIRECTION OF MANAGEMENT DEVELOPMENT ACTIVI TIES

A. Management Development Activities

Since the inception of the national family planning program, the existing program management system, including target setting, records, and reporting, program evaluation and supervision, has focused more on program quantity than on quality. Looking to the future, the government will focus its management efforts on enhancing program quality through the development of innovative schemes for strengthening existing management, and integration of the program with general health services and maternal and child health programs.

1. Improvement of the Current Management System

A brief summary of the government's efforts in development activities which are in collaboration with KIPH are as follows:

a) The government is in a position to improve the existing evaluation system under the new concept of MIS through revising and supplementing the present record and reporting forms in accordance with the MIS research findings of KIPH. Newly designed recording and reporting forms, containing data revelant to field program operation and management, were adopted in use throughout the country from 1981. In addition, the KIPH will strengthen data processing and analytical capability to insure faster and broader feedback availability for the program managers by establishing a Health Information Research Unit at the KIPH.

b) To strengthen program evaluation and field supervisory capability, a functional and adaptable manual on program evaluation and supervision will be developed at KIPH. Since provincial family planning supervisory nurses and health center senior

workers are responsible for various managerial problems, such as service statistics, the KIPH plans to intensify the existing training course, focusing on enrichment of techniques and knowledge regarding program management and administration.

c) Development of a regular workshop course for various level program managers and administrators is another goal for the KIPH. Past training programs conducted for program managers and administrators were primarily oriented toward increasing awareness of population and family planning problems rather than improving program management skills. A newly designed course would equip program managers and administrators in the field with basic management techniques and knowledge necessary for efficient program operation.

d), In order to encourage revitalization of central and provincial level supervisory activities, quarterly joint meetings are planned. This will not only increase rapport and closer coordination between managers at the central level and those at the local level, but also will result in family planning supervisory activities conducted more efficiently than has been in the past. The annual Family Planning Evaluation Seminar usually takes considerable time to develop solutions for presented problems; however, quarterly meetings of the supervisory teams should improve this.

e) Since the program inception, there have been few research and evaluation activities in the field of program management and operation. Examining some of the evaluative research performed regarding program management and administration reveals a focus only on problems connected with program implementation, and very little attention on how to take care of the problems leading to a solution. As far as the future direction for research and evaluation, KIPH hopes to maximize program effectiveness by placing greater emphasis in the area of program operation and management.

2. Management Efforts in Integration of Family Planning with Maternal and Child Health

The various efforts explained above should accomplish a great deal toward strengthening the existing management functions of family planning in Korea. However, the most important thing for the further establishment of family planning

direction in Korea is to set up a well-defined management system and program network. The Korean government has recently promulgated a thorough plan expanding and strengthening the primary health care delivery system, including a comprehensive maternal and child health program. The first action taken in accordance with this government policy was an integrated health worker training program, conducted since 1978 by the KIPH. The main purpose of integrated health worker training is to integrate the existing single-line workers, such as those in MCH, T.B., and F.P. into a multi-purpose worker who will be capable of providing comprehensive health services at the community level. Through a loan of the World Bank, a large scale renovation and construction plan has been adopted by the Korean government. The first part established 102 MCH/FP centers throughout the country, including midwifery training of auxiliary health workers to improve home delivery services. The second part strengthens the training function of the KIPH by expanding training facilities and introducing modern audio-visual training aids and equipment to accelerate integrated worker training. A detailed plan of action to fully utilize multi-purpose workers has not been fully developed. The accepted opinion is that the present family planning program should be gradually integrated with health programs such as maternal and child health, in order to increase the current family planning practice rate through enhancing comprehensive service availability.

Another viewpoint to be emphasized is that a scheme for integrating family planning with general health services can not be achieved only by integrating health worker activities at the peripheral level. To reach the eventual goal of having a comprehensive health care delivery system, organization as well as functional integration of various health programs must be materialized. The integration effort must be directed 1) to unify the entire program network from the central to the peripheral level, 2) to develop a scheme of manpower supply in support of an integrated effort, and 3) to establish a unique program management system to deal with numerous matters regarding program planning and budgeting, recording and reporting, program monitoring, and control and supervision. To achieve this in Korea, it is urgent to develop an innovative scheme of program management which is easily adaptable to integrate the present family planning program with health services in general, including maternal and child health.

B. General Descriptions of the Role of International Agencies, Overseas Training Courses, Research Investment, and Use of Consultants

The availability of training and education in management of population and family planning programs has been limited, both in the academic setting of universities and in research institutions. The exceptions are the few courses offered by the KIPH. However, those have been more specifically focused on the socio-demographic aspects of population. Fellowship training, sponsored by donor agencies abroad, has usually also concentrated on the demographic, sociological and statistical aspects of population and family planning.

Analyzing different aspects of past research and evaluation activities regarding program management and integration, there are few references and sources. Foreign consultant activity in this area is also no exception. There are, of course, many noted scholars who have specialized in business management and administration; however, employment and periodic utilization of these academic personnel is of questionable value because there is often not sufficient effort to reduce the gap between academic theory and program practice.

Under these circumstances, what areas of special attention have to be emphasized and what additional input is needed, for more successful implementation of family planning in Korea? As an effort to improve program management and operation, it is desirable 1) to build management research manpower through the development of overseas training programs as well as the development of training programs within the country, 2) to support management research projects through the provision of research funds and technical assistance, especially for the projects relevant to integrated FP/health services, 3) to exchange experiences in program management under different program settings through regional and interregional workshops, seminars, study tours, etc., 4) to assist development of health manpower for integrated FP/health services through curriculum development, trainer's training, adequate training facilities, etc., and 5) to assist the improvement of rapid feedback by strengthening the data processing and data bank system.

In conclusion, Korea is striving to increase the effort in the area of improving managerial performance to insure effective program management and administration. The government believes that effective family planning program implementation will be the only way to attain the specific goal of population control set forth in the government's long-term population plan. Moreover, the successful implementation of family planning program depends largely on the improvement of the family planning management system.

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